true worth of orthoptic training and to differentiate into groups those cases which will benefit by it quickly, those which will require protracted training and those for whom it is clearly a waste of time and trouble.

Miss Pugh is particularly well qualified to write with authority on this subject. She is the Medical Officer in charge of the Orthoptic department at the Moorfields Eye Hospital, where a very considerable number of patients come under her care and where she has the opportunity of following up the post-operative results of twelve surgeons and the resident staff. The author has given a careful survey and as far as possible an assessment of the place and value of orthoptic training in ophthalmology.

Chapters 1 and 2 are concerned with the classification of cases of strabismus and their investigation preliminary to treatment. Chapter 3 is devoted to a full description of binocular vision. Chapter 4 deals with methods of training and chapter 5 with the training of such difficult cases as those which have abnormal binocular projection and abnormal retinal correspondence. Chapter 6 is concerned with the selection of cases for operation and post-operative results. The appendix contains an account of a number of modern orthoptic instruments and their development.

This little book will afford a useful guide to the present status of orthoptic training. The author has given a well balanced account of this subject. The print, paper, and illustrations are excellent.

CORRESPONDENCE

"POSTERIOR NEEDLING" IN THE TREATMENT OF LAMELLAR AND OTHER FORMS OF SOFT CATARACT

To the Editors of The British Journal of Ophthalmology.

Sirs,—Dr. Ballantyne's paper on the above subject in the September number of the Journal contains some unjustifiable criticisms of the anterior needling operation which should not, I think, pass unchallenged. The disadvantages he speaks of are unduly, and I feel sure unintentionally, exaggerated in order to throw into relief the benefits of a posterior needling.

In the first place, swelling of the lens can only take place when the capsule is intact, or practically intact as is the case after an
imperfect needling, the result of faulty technique; and glaucoma, as Dr. Ballantyne rightly says, is likely to occur under these conditions. To talk of swelling of the lens when masses of opaque lens matter are protruding from the opening in the capsule and filling the anterior chamber is a mistaken use of the term. Glaucoma may occur under those circumstances due to the lens matter blocking up the angle of the anterior chamber but such a complication only rarely takes place because the angle is not usually blocked throughout its whole circumference, thus leaving a sufficient number of open channels through which the aqueous fluid can drain away.

The incision in the capsule must be made as large as possible, but one can never say whether any individual operator has opened the capsule satisfactorily or not, unless one knows his method of manipulating the needle.

There is no doubt that the uncertainties of the anterior needling operation, which Dr. Ballantyne speaks of, are mainly due to an imperfect opening of the capsule, and if I personally am compelled to do more than one needling (apart from the final capsulotomy), which I seldom have to do, I immediately suspect my operative technique, but do not condemn the operation.

Abundance of lens matter in the anterior chamber following a successful needling occasionally produces some irritation of the iris, when it may be advisable to do a curette evacuation, and the same procedure is necessary in those cases of glaucoma, but an anaesthetic is by no means always unavoidable for this operation, and I have generally performed it without. Nor do I find the "conditions unfavourable."

Some operators prefer to do a curette evacuation in any circumstances in order to shorten the waiting period which is otherwise necessary before the lens matter becomes completely absorbed; and I myself am in favour of this procedure, especially in these days when the risk of septic infection can be practically eliminated.

I am not, therefore, one of those operators who "must have experienced some anxiety" in dealing with cataract by the anterior needling operation. As regards the posterior needling operation, I notice that 2 or 3 needlings are generally to be expected, and the needle is entered 5 mm. behind the sclero-corneal margin which is very near, if not even through, the ciliary body, and which I should say is at least undesirable.

Results of experiments conducted many years ago by Sir John Parsons appeared in the *Royal London Ophthalmic Hospital Reports*, Vol. XV, and were described again by him, in conjunction with similar works by others on the same subject, in Vol. II of his book on the Pathology of the Eye; and the impression left
on my mind after reading the pathological details has been to discourage me from entering the vitreous by puncturing the sclerotic with a needle or a knife, unless it is absolutely necessary. I do not think the questions of payment for a nursing home or missing a few weeks in a child’s education period should have any weight in discussing the merits or demerits of any operation. It is entirely a question of which operation is the safest and best for the patient. I do not share Dr. Ballantyne’s surprise that the posterior needling operation is not more popular.

Yours faithfully,
MALCOLM L. HEPBURN.

LONDON,
October 1, 1936.

BIFOCALS

To the Editors of The British Journal of Ophthalmology.

Sirs,—Bifocal lenses, in which no displacement of the object is apparent to the observer upon the visual axis passing from the distance portion into the reading portion, have been produced by J. & R. Fleming for a large number of years. They have been marketed under the name of “Monaxial.” They are constructed of one piece of glass of the style termed “solid bifocals,” although originally made in a “visible” form, they have been produced in an “invisible” style since 1929.

Yours faithfully,
J. & R. FLEMING, LTD.
A. P. COULDEN.

LONDON,
October 6, 1936.

Mr. Williamson-Noble has asked us to call attention to the fact that at the end of his article he mentioned that a similar lens had already been manufactured—Editors.

OBITUARY

REGINALD THORPE

We regret to record the death of Reginald Thorpe on October 9, 1936, aged 75 years. He was the younger son of the late John Thorpe, Esq., of the Chase, Clapham, and was born in 1861. Thorpe was educated privately and at Trinity College, Dublin, and entered St. George’s Hospital in 1883. He suffered much from...